

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home#: \_\_\_\_\_

Gender (circle one):    **MALE**                      **FEMALE**

Work#: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single “healthy” diet that will work for everyone.*
- *Just because food is considered “healthy”, does not mean it is “healthy” for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale.***
- *Our procedures are safe and painless.*

## Thyroid Patient Symptom Survey

[Please Check All Symptoms You Experience Even if Occasionally]

1. Weight Gain	YES	NO
2. Slower Heart Rate	YES	NO
3. Poor Memory	YES	NO
4. Muscle Weakness	YES	NO
5. Menstrual Irregularities	YES	NO
6. Infertility	YES	NO
7. Inability to Concentrate	YES	NO
8. Hoarseness	YES	NO
9. Fatigue	YES	NO
10. Essential Hypertension	YES	NO



11. Dry Skin	YES	NO
12. Depression	YES	NO
13. Cold Intolerance	YES	NO
14. Brittle Nails	YES	NO
15. Cold Hands & Feet	YES	NO
16. Constipation	YES	NO
17. Difficulty Swallowing	YES	NO
18. Elevated Cholesterol	YES	NO
19. Eyelid Swelling	YES	NO
20. Hair Loss	YES	NO
21. Hypotension	YES	NO
22. Irritability	YES	NO
23. Muscle Cramps	YES	NO
24. Nervousness	YES	NO
25. Puffy Eyes	YES	NO
26. Throat Pain	YES	NO